67:16:03:06. Basis of reimbursement -- Inpatient services -- Hospitals with more than 30 Medicaid discharges. Reimbursement for services provided to a patient admitted to an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is based on DRGs and weight factors, the hospital's target amount, and capital and education costs per day. A hospital's base target amount is calculated from the cost report submitted to the Medicare program for the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, and adjusted annually for inflation as appropriated by the Legislature and changes to the DRG weight factors. A list of the DRGs and their associated weight factors may be obtained on the department's website located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp.

The department shall use the following method to calculate the amount of reimbursement:

(1) Multiply the hospital's target amount by the weight factor of the DRG assigned to the claim;

(2) Multiply the daily capital and education cost for the hospital by the number of days the patient was in the hospital; and

(3) Add the products of subdivisions (1) and (2) of this section.

In addition to the regular DRG reimbursement, the department shall pay for a cost outlier if the claim qualifies for the cost outlier as defined in § 67:16:03:01. The amount of the cost outlier payment is equal to 90 percent of the cost outlier.

When calculating the rate of reimbursement, the department uses only those ICD-9-CM codes that reflect the services furnished to or on behalf of the eligible individual and the conditions that affected the treatment or extended the length of the individual's stay.

If a patient is transferred, referred, or discharged to another hospital or another type of special care facility and the transfer, referral, or discharge is medically necessary or if a patient leaves the hospital against medical advice, reimbursement is on a per diem basis. To determine the rate of reimbursement, multiply the hospital's target amount by the weight factor of the DRG assigned to the claim, divide the result by the geometric mean length of stay, multiply the result by the number of days the individual was an inpatient, and add the hospital's daily capital and education cost. The amount paid may not exceed 100 percent of the allowed DRG reimbursement.

~~The amount of reimbursement calculated above is reduced by 11.48 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted and then increased by 0.5 percent for hospitals that are not classified as Medicare Critical Access or Medicaid Access Critical. Hospitals that are classified as Medicare Critical Access or Medicaid Access Critical are exempt from the 11.48 percent reduction in reimbursement. The rate of reimbursement is increased by 1.8 percent for hospitals that are classified as Medicare Critical Access or Medicaid Access Critical.~~

For inpatient costs for Medicaid Access Critical facilities the department uses the facility's cost report to determine whether any adjustment to reimbursement is necessary for amounts due the provider.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; transferred from § 67:16:03:12, 12 SDR 6, effective July 28, 1985; exemptions for certain hospitals transferred to § 67:16:03:06.02, 13 SDR 8, effective August 3, 1986; 15 SDR 2, effective July 17, 1988; 17 SDR 180, effective May 27, 1991; 22 SDR 143, effective May 9, 1996; 24 SDR 19, effective August 21, 1997; 24 SDR 144, effective April 30, 1998; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 39, effective September 29, 2004; 36 SDR 215. effective July 1, 2010; 36 SDR 215, adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 39 SDR 15, effective August 6, 2012.

General Authority: SDCL 28-6-1(2), 28-6-1.1.

Law Implemented: SDCL 28-6-1(2), 28-6-1.1.

Reference: South Dakota Medicaid State Plan, Attachment 4.19-A, page 1. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

Cross-References:

Basis of reimbursement – Outpatient services other than outpatient laboratory and outpatient surgical procedures, § 67:16:03:06.01.

Basis of payment -- Inpatient services -- Hospitals with less than 30 Medicaid discharges, § 67:16:03:06.03.

Reimbursement of outpatient laboratory services, § 67:16:03:06.07.

Use of ICD-9-CM, § 67:16:01:26.

67:16:03:06.01. Basis of reimbursement -- Outpatient services other than outpatient laboratory and outpatient surgical procedures. Reimbursement for outpatient hospital services for an in-state acute care hospital that had more than 30 inpatient Medicaid discharges in the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, is adjusted annually for inflation as appropriated by the Legislature and is based on reasonable costs as determined by the hospital's Medicare Cost Report from fiscal year 2010 with the following exceptions:

(1) Costs associated with the certified registered nurse anesthetist services that relate to outpatient services are included as allowable costs; and

(2) All capital and education costs incurred for outpatient services will be included as allowable costs.

Reimbursement for outpatient hospital services for the remaining in-state acute care hospitals is at 90 percent of their usual and customary charge for the service provided.

Reimbursement for out-of-state hospital outpatient services is calculated at ~~33.07 percent~~a percentage of their usual and customary charge as appropriated by the Legislature.

Costs for outpatient services incurred within three days immediately preceding the inpatient stay are included in the inpatient charges unless the outpatient service is not related to the inpatient stay. This provision applies only if the facilities providing the services are owned by the entity.

Outpatient laboratory services are excluded from the provisions of this rule and are payable according to § 67:16:03:06.07.

Outpatient surgical procedures are payable according to § 67:16:03:06.11.

~~The amount of reimbursement calculated above is reduced by 11.48 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted and then increased by 0.5 percent for in-state hospitals that are not classified as~~

~~Medicare Critical Access or Medicaid Access Critical. Hospitals that are classified as Medicare Critical Access or Medicaid Access Critical are exempt from the 11.48 percent reduction in reimbursement. The rate of reimbursement is increased by 1.8 percent for in-state hospitals that are classified as Medicare Critical Access or Medicaid Access Critical.~~

For outpatient costs for Medicaid Access Critical facilities the department uses the facility's cost report to determine whether any adjustment to reimbursement is necessary for amounts due the provider.

Source: 12 SDR 6, effective July 28, 1985; 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 180, effective May 27, 1991; 18 SDR 198, effective June 3, 1992; 22 SDR 143, effective May 9, 1996; 23 SDR 232, effective July 10, 1997; 25 SDR 116, effective March 24, 1999; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 36 SDR 215, effective July 1, 2010; 36 SDR 215, adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 39 SDR 15, effective August 6, 2012.

Reference: South Dakota Medicaid State Plan, Attachment 4.19-B, page 1b. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:03:06.04. Basis of reimbursement -- Inpatient services -- Out-of-state hospitals. The department shall reimburse out-of-state inpatient hospital services by making a prospective payment equal to the payment allowed by the Medicaid program in the state in which the hospital is located. If the Medicaid program in the hospital's home state refuses to price a claim, the payment allowed is ~~39.02 percent~~a percentage of the provider's usual and customary charge as appropriated by the Legislature.

Source: 15 SDR 2, effective July 17, 1988; 16 SDR 235, effective July 5, 1990; 17 SDR 200, effective July 1, 1991; 30 SDR 26, effective September 3, 2003; 31 SDR 107, effective February 1, 2005; 36 SDR 215, effective July 1, 2010; 36 SDR 215 adopted June 11, 2010, effective July 1, 2011; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 224, effective July 1, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Reference: South Dakota Medicaid State Plan, Attachment 4.19-B, page 1b. Copies may be obtained from the Department of Social Services, Division of Medical Services, 700 Governors Drive, Pierre, South Dakota 57501.

67:16:14:06. Payment for items dispensed by pharmacy. Payment for items covered under this chapter and dispensed by a pharmacy is made at the lowest of the following:

(1) The provider's usual and customary charge;

(2) The estimated acquisition cost of the drug dispensed, plus a dispensing fee contained on the departments website located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~of $4.30~~;

(3) The payment limit established by the United States Department of Health and Human Services under the provisions of 42 C.F.R. § 447.332 (July 1, 1987) for multiple-source drugs, plus a dispensing fee ~~of $4.30~~contained on the departments website located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp; or

(4) The payment limit established by the department, in consultation with the contractor, for drugs contained on the state MAC list, plus a dispensing fee contained on the departments website located at http://dss.sd.gov/medicalservices/providerinfo/feeschedule.asp~~of $4.30~~.

For purposes of this section, the provider's usual and customary charge is that charge made by the provider to third-party payers for a specific item on the day the item is supplied.

Source: SL 1975, ch 16, § 1; 1 SDR 77, effective May 29, 1975; 4 SDR 10, effective August 28, 1977; 7 SDR 23, effective September 18, 1980; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 13 SDR 8, effective August 3, 1986; 14 SDR 153, effective May 23, 1988; 16 SDR 234, effective July 1, 1990; 17 SDR 200, effective July 1, 1991; 22 SDR 93, effective January 7, 1996; 29 SDR 113, effective February 13, 2003; 31 SDR 21, effective August 25, 2004; 37 SDR 236, effective June 28, 2011; 37 SDR 236, adopted June 8, 2011, effective July 1, 2012; 38 SDR 224, effective July 1, 2012.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-References:

Upper limits for multiple-source drugs, 45 C.F.R. § 447.332.

Payment for drugs dispensed by physician, § 67:16:14:06.06.

Payment for drugs dispensed by PHS provider, § 67:16:14:06.09.

Federal drug list, http://www.cms.hhs.gov/home/medicaid.asp.

State MAC list, http://dss.sd.gov/medicalservices/providerinfo/pharmacy/index.asp.